THE STATE OF DELAWARE

DL-1: Request for Donated Leave

NOTE: This Page is CONFIDENTIAL

Part I - To be completed by employee requesting donated leave

Name (Last, First, MI) Social Security # Date of Birth

Mailing Address (Street, City, State, Zip)

Agency (Name and Location) Date of Hire Work Telephone #

Illness* of: Employee Family Member of Employee (Check one box)

Family Member's Name: _____ Relationship to Employee: _____

Family Member's Present Address: _____

How long has the Family Member been a resident at the present address? _____

Date of Accident/ beginning of Illness _____ Date Disability began _____ Date Returned to Work _____

Briefly describe nature of illness/injury

Name of treating physician Physician's address Physician's Telephone # Treatment Date

Date all sick leave exhausted _____ Date one-half annual leave exhausted _____

Date all annual leave exhausted _____

Describe any other income you are receiving or are eligible to receive as a result of your disability.
(Examples: Social Security, Worker's Compensation, Disability Insurance, Pensions, etc.)

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, medical institution, pharmacy, governmental agency, or my present employer having information concerning me, to release said information to the State of Delaware or its designated representative to be used for determination of my eligibility for Donated Leave. This authorization shall be valid from the date signed through the duration of this claim.

Employee Signature Date

Part II – To be completed by the employee's agency personnel/payroll office

The above-named employee has:

- used, or will use, all accrued sick leave on _____
- used, or will use, one-half of his/her accrued annual leave on _____
- used, or will use, all of his/her accrued annual leave on _____
- has been employed by the State for (6) months as of _____
- last worked on _____

(NOTE: For illness* or injury of a family member, employee must have used all of his/her sick and annual leave.)

_____ _____ _____

Authorized Signature | Date | Recipient's Agency

Agency Address – (please include SLC): _____

Part III – To be completed by the Donated Leave Bank Committee (Leave Bank Requests Only)

We have reviewed the donated leave request to determine if the employee meets all criteria for the Donated Leave Program.

We recommend: _____ Denial _____ Approval granted through _____. For applicant to be eligible to receive Donated Leave beyond the above date, applicant must submit physician's certification certifying continued disability/illness.

Based upon hours currently available in the State of Delaware Donated Leave Bank we further recommend that _____ be awarded _____ hours of donated leave from the State of Delaware Donated Leave Bank.

_____ _____ _____ _____

Agency Representative | Date | State Personnel Office Representative | Date

_____ _____

Employee Representative | Date

Part IV –To be completed by State Personnel Director or Designee (Donated Leave Bank Only)

I hereby certify that I have reviewed this application and the recommendation of the Donated Leave Bank Review Committee and hereby approve/disapprove _____ for the receipt and use of donated leave. Further, based upon the recommendation of the Donated Leave Bank Review Committee, I am authorizing transfer of _____ hours from the State of Delaware Donated Leave Bank to _____.

_____ _____

State Personnel Director/Designee | Date

Upon completion, please forward to applicant's agency personnel/payroll office.

Part V – To be completed by applicant's agency personnel/payroll office

I hereby certify that (1) this applicant has been an officer or employee of this State for at least 6 months (2) has used all of his/her sick time and one-half of his/her annual leave (for illness/injury of family member – has used all of his/her sick time and all of his/her annual leave) and (3) has established medical justification for such receipt, which shall be renewed every 30 days. I further certify that the applicant has been credited with _____ hours of Donated Leave from the State of Delaware Donated Leave Bank.

_____ _____

Authorized Signature Date

**Illness is defined as any illness or injury to the employee or to a member of an employees family which is diagnosed by a physician and certified by the physician as rendering the employee or the member of the employees family unable to work, or in the case of family member who does not work the medical equivalent of "unable to work" for a period greater than 5 calendar weeks.*

THE STATE OF DELAWARE

Request to Receive Donated Leave

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Part VI-To be completed by physician who is treating employee or employee's family member.

1. Name of Patient _____ Date of Birth _____

Present Address _____ SS# _____

2. If patient is the employee's seriously ill family member please complete the following:

- Is hospitalization of family member (patient) required? Yes No
- Does (or will) patient need help for basic medical, hygiene, nutrition, safety or transportation? o Yes o No
- Is the employee's presence necessary, or would it be beneficial for care of the patient? o Yes o No
- Please describe the care required and the estimated time allotted for treatment.

_____
_____
_____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

This patient is responsible for the completion of this form without expense to the State of Delaware. We must have comprehensive medical information in order to evaluate the insured's claim for Donated Leave.

1. HISTORY

(a) When did the symptoms first appear or accident happen? Mo. _____ Day _____ 20_____

(b) Date disability began Mo. _____ Day _____ 20_____

(c) Has patient ever had same or similar condition? Yes _____ No _____

If "yes" please give details _____

(d) Is condition due to injury or sickness arising out of patient's employment? Yes _____ No _____ Unknown _____

_____

4. DIAGNOSIS (including any complications)

(a) When did symptoms first appear or accident happen? Mo. _____ Day _____ 20_____

(b) Diagnosis and ICD-9 or DSM-IV Code (including any complications)

(c) Subjective symptoms

(d) Objective findings (Including current x-rays, EKG's, Laboratory Data and any clinical findings)

5. TREATMENT DATES

(a) Date of first visit Mo. _____ Day _____ 20_____

(b) Date of last visit Mo. _____ Day _____ 20_____

(c) Frequency Weekly _____ Monthly _____ Other(specify) _____

1. NATURE OF TREATMENT (including surgery and medications prescribed, if any)

Will treatment substantially improve function and employability? Yes _____ No _____

If yes, please specify.

2. PROGRESS

(a) Has patient recovered? _____ improved? _____ unchanged? _____ retrogressed? _____

(b) Is patient bed confined?_____ hospital confined?_____ ambulatory?_____ house confined? _____

(c) Has patient been hospital confined? Yes_____ No_____

If yes, give name and address of hospital _____

Confined from _____ through _____
_____

3. CARDIAC (if applicable)

(a) Functional capacity Class 1 (no limitation) _____ Class 2 (slight limitation) _____

(American Heart Assoc.) Class 3 (marked limitation) _____ Class 4 (complete limitation) _____

(b) Blood Pressure (last visit) Systolic _____ Diastolic _____

4. LIMITATION (if there is a limitation, check and describe below)

standing _____ climbing _____ bending _____ use of hands _____
sitting _____

walking _____ stooping _____ lifting _____ psychological _____ other _____

5. PHYSICAL IMPAIRMENT (as defined in Federal Dictionary of Occupational Titles)

____ Class 1 – no limitation of functional capacity; capable of heavy work. No restrictions (0-20%)

____ Class 2 – medium manual activity (15-30%)

____ Class 3 – slight limitation of functional capacity; capable of light work (35-55%)

____ Class 4 – moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (60-70%)

____ Class 5 – severe limitation of functional capacity; incapable of minimal (sedentary) activity (75-100%)

____ Remarks:

Do you believe the patient is competent to endorse checks and use the proceeds thereof? Yes ___ No ___

6. EXTENT OF DISABILITY

	From Patient's Regular Occupation	From any Occupation
(a) Is patient now totally disabled?	Yes _____ No _____	Yes ____ No ____
(b) If no, when was patient able to go to work?	Mo.____ Day____ 20____	Mo._____Day____ 20___
(c) If yes, when do you think patient will be able to resume any work?	Mo.____ Day____ 20____	Mo._____Day____ 20___

7. REMARKS

Date	Signature (attending physician)	Degree	Telephone Number
Street Address	City	State	Zip Code

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